APPENDIX 14
Published Notice of Proposal

11:3-1.9 Rates and policy forms

(a) (No change.)

(b) The governing committee shall file all rates, rules, surcharges, minimum premiums, classifications and policy forms to be used by CAIP for the prior approval of the Commissioner. Proceedings to review these filings shall be conducted pursuant to N.J.S.A. 17:29A-1 et seq. All rates shall consider the experience of risks insured by the plan and shall not be excessive, inadequate or unfairly discriminatory. **Every rate filing shall include an analysis of the adequacy of the rating plans.**

(c) [For any risk with less than 10 vehicles, the premium] **Premiums for risks** shall be subject to [a merit] **the** rating plan established in the plan of operation. [Every rate filing shall include an analysis of the adequacy of the merit rating plan.]

(d) Any risk with [10] **five** or more vehicles not including trailers and semi-trailers shall be considered as a fleet. CAIP shall file base rates for fleets with the Commissioner for his or her prior approval which are different than the rates for non-fleet risks if CAIP determines that the loss expectancy of fleet risks insured by CAIP is different than the loss expectancy of non-fleet risks insured by CAIP.

[(e) Fleet risks shall be subject to an experience rating plan established in the plan of operation, which shall set forth the criteria for eligibility of the experience rating plan. If any fleet risk is determined to be ineligible for the experience rating plan, the risk shall be subject to a merit rating plan established in the plan of operation.

(f) Any risk with basic limits premium of $100,000 or greater shall also be subject to a retrospective rating plan established in the plan of operation. In the event CAIP finds that the premium from all retrospectively rated risks combined is inadequate, or excessive, CAIP shall file with the Commissioner for his or her prior approval a change in the retrospective rating formulas, including a percentage surcharge on all retrospectively rated risks if necessary, so that the total premium from retrospectively rated risks is adequate based on the combined experience of retrospectively rated risks insured by the plan.]

(a)

DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Health Benefits Plans
Prompt Payment of Claims
Organized Delivery Systems; Reports
Proposed Amendments: N.J.A.C. 11:22-1.2, 1.9 and 1.10

Authorized By: Holly C. Bakke, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17B:30-13.1, 17B:30-23 et seq. and 26:2J-15b.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2003-213.

Submit comments by August 1, 2003 to:

Douglas A. Wheeler, Assistant Commissioner
Legislative and Regulatory Affairs
Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325
Fax: (609) 292-0896
Email: legsregs@dobi.state.nj.us

The agency proposal follows:

Summary

N.J.A.C. 11:22-1, Prompt Payment of Claims, establishes standards for the prompt payment of claims by carriers or their agents relating to health benefit plans and dental plans issued by those carriers. N.J.A.C. 11:22-1.9 requires that various quarterly and annual reports be submitted by these carriers. The Department of Banking and Insurance (Department) is now proposing to amend these provisions. The major focus of the proposed amendments is N.J.A.C. 11:22-1.9(a) and (b). Subsection (a) requires the filing of a report (Appendix A) on a quarterly basis, on the timeliness of claims payments. N.J.A.C. 11:22-1.9(a) also requires the filing of a quarterly report (Appendix B) on the reasons for claim denials and the late payment of claims. Although Appendix B reports are filed quarterly, the filing in the fourth quarter is an annual report which, pursuant to subsection (b), must be audited.

The Department is recodifying N.J.A.C. 11:22-1.2 into subsection (a), which contains the definitions that apply to the terms in the chapter and subsection (b), which only applies to terms used in Subchapter 1. The new subsection (b) provides a definition of organized delivery system (ODS), which is included in the definition of a "payer" at N.J.S.A. 17B:30-26.

The Department is amending N.J.A.C. 11:22-1.9(a) and (b) to also include references to ODS in order to implement the requirements imposed by N.J.S.A. 17B:30-26 et seq., which subject such systems to the reporting requirements of these rules.

The Department is also amending N.J.A.C. 11:22-1.9 to permit carriers with a minimal amount of health insurance business in New Jersey to request an exemption from the requirement to file an audited report as currently required by N.J.S.A. 17B:30-30 and N.J.A.C. 11:22-1.9(b). Presuming they meet the criteria under which such requests will be evaluated, the granting of such an exemption will enable qualifying companies to avoid the substantial expense of having their annual report audited by a private auditing firm. This "de minimis" exception to the requirement that all annual reports submitted pursuant to N.J.S.A. 17B:30-30 be audited recognizes that, in certain cases, no substantial public policy considerations are realized by having the annual reports of health insurance companies which write a minimal volume of health insurance business in New Jersey independently audited.

N.J.A.C. 11:22-1.9(e) is a new provision which establishes three conditions that must be satisfied in order for a carrier to apply for an exemption from the requirements to have the annual report audited and to file the auditor's report with the audited annual report. These conditions are: (1) the Appendix B annual report has been filed; (2) any required Appendix A reports have been filed; and (3) the total New Jersey premium of the carrier (on a consolidated basis) is less than $5 million.

Proposed N.J.A.C. 11:22-1.9(f) is a new provision which provides the criteria that the Commissioner shall apply when considering a carrier's request for an exemption from the requirements to have the annual report audited and to submit the auditor's report with the annual report.

In new N.J.A.C. 11:22-1.9(g), the Department is permitting a carrier that has been granted an exemption from filing an audited report to also be exempt from filing quarterly Appendix A and B reports the following year. However, the carrier would still be required to file an audited annual Appendix B report for that year unless another exemption was obtained.

The Department is amending N.J.A.C. 11:22-1.10 to include references to ODS in order to clarify that they are also subject to that provision concerning remediation and penalty.

The Department's rule proposal provides for a comment period of 60 days, and, therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

The proposed amendments will have a positive impact on insurers and ODS. Those insurers that are able to satisfy the criteria for an exemption will no longer have to incur the costs associated with providing the Department with the report of an auditing firm detailing the reasons for claims denial and late claims payments. Furthermore, such carriers would not incur the costs of filing quarterly reports for the subsequent year. Because the amount of business written by these carriers is small in relation to the entire health insurance market, and because the Department will continue to monitor these companies on an annual basis, there is minimum, if any, impact on the Department's ability to monitor the timeliness of claim payments.

Pursuant to N.J.S.A. 17B:30-23 et seq., these rules clarify that these reporting requirements are applicable to ODS. Although there are no ODS currently licensed to operate in this State, the impact of these rules will be the same on any ODS that become licensed to operate in this State as it is on insurers, with respect to complying with the requirements of these rules. Those ODS that are able to satisfy the criteria for an exemption will not incur the costs associated with providing the Department with the report of an auditing firm detailing the reasons for claims denial and late claims payments. Furthermore, such ODS would not incur the costs of filing quarterly reports for the subsequent year.

Economic Impact

The proposed amendments will have a positive economic impact on those insurers that are able to satisfy the conditions for obtaining an exemption. Based on current premium volume, the Department estimates about 30 carriers out of the approximately 80 carriers who file the report might qualify to apply for the exemption. Since there are no ODS currently licensed to operate in this State, the Department cannot determine how many ODS that may file in the future might qualify for an exemption. However, the proposed amendments will have a positive economic impact on those ODS that become licensed to operate in this State, that are able to satisfy the conditions for obtaining an exemption. Those insurers and ODS that are not able to obtain an exemption will incur cost associated with obtaining the report of an auditing firm detailing the reasons for claims denial and late claims payments.

Federal Standards Statement

A Federal standards analysis is not required because the proposed amendments are not subject to any Federal standards or requirements.

Jobs Impact

The Department does not anticipate that the proposed amendments will result in the generation or loss of jobs.

Agriculture Industry Impact

The Department does not expect any impact on the agriculture industry from the proposed amendments.

Regulatory Flexibility Analysis

The proposed amendments may apply to any carrier that constitutes "a small business" as that term is defined in the Regulatory Flexibility Act at N.J.S.A. 52:14B-16 et seq. The Department's proposed amendments do not add or require any new reporting, recordkeeping or other compliance requirements. The Department does not anticipate that insurers or ODS will need to employ professional services in order to comply with the amendment provisions. Pursuant to N.J.S.A. 17B:30-23 et seq., these rules clarify that these reporting requirements are applicable to ODS. Although there are no ODS currently licensed to operate in this State, the impact of these rules will be the same on ODS as it is on insurers in complying with the requirements of these provisions.

The Department believes that, unless the conditions specified in the proposed amendments are satisfied, it continues to be appropriate to require the submission of an audited annual report in accordance with N.J.S.A. 17B:30-30 and N.J.A.C. 11:22-1.9. Carriers and ODS of all sizes enter into contracts with providers and insureds to pay claims promptly. When payment does not occur because a claim is denied, it is appropriate for payers to provide information on the reasons why a claim was disputed or denied, regardless of the carrier's size. However, the Department has determined that exempting companies with a minimal amount of health insurance business from the requirement that such reports be independently audited is consistent with the intent of the statute, which is to ensure the prompt payment of claims and the adequate tracking and accurate reporting of statistically significant information.

Smart Growth Impact

The proposed amendments will not have an impact on the achievement of smart growth or the implementation of the State Development and Redevelopment Plan.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

11:22-1.2 Definitions

(a) The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

. . .

(b) The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Organized delivery system" or "ODS" means an organized delivery system that is either certified or licensed pursuant to N.J.S.A. 17:48H-1 et seq.

11:22-1.9 Reporting requirements

(a) A carrier **or ODS** shall report to the Department [quarterly] on the timeliness of claims payments in the format set forth in Appendix A to this subchapter, incorporated herein by reference, **on a quarterly basis,** and on the reasons for denial and late payment of claims in the format set forth in Appendix B to this subchapter, incorporated herein by reference, on an annual and quarterly basis. Instructions for these documents are provided in subchapter Appendix A-1 and Appendix B-1, respectively, incorporated herein by reference. Due dates for the reports are as follows: May 15 for the first quarter; August 15 for the second quarter; November 15 for the third quarter; and March 31 for the fourth quarter in Appendix A and the annual report for Appendix B.

(b) The annual report **on the reasons for denial and late payment of claims** shall be audited by a private auditing firm at the expense of the carrier **or ODS**. The annual report shall be accompanied by the report of the auditing firm that reviewed the report. In addition to the Department, copies of the audited annual report shall be sent to the Governor and the majority and minority offices of the Legislature.

(c)-(d) (No change.)

(e) A carrier or ODS may request an exemption from the requirements to have the annual report required by (b) above audited and to submit a report of the auditing firm. This exemption must be obtained on an annual basis. Such an exemption may be granted if the carrier or ODS meets the following conditions:

1. The carrier or ODS must file the annual Appendix B report required by (a) above in a timely manner. The report shall be accompanied by a request for exemption from the requirements that the report be audited and that a report of the auditing firm be submitted;

2. The carrier or ODS shall have filed the four quarterly Appendix A reports required by (a) above in a timely manner, unless the carrier or ODS was exempted from such filing pursuant to (g) below; and

3. The annual premiums earned by the carrier or ODS in New Jersey for all health benefits plans as defined in N.J.A.C. 11:22-1.2 were less than $5 million in the year covered by the annual report for which the exemption is requested. The carrier or ODS shall provide, in its request for exemption, a reconciliation of these premiums to the net earned premiums for "health benefit plans" as defined at N.J.A.C. 11:4-23A.2 and as reported to the Commissioner pursuant to N.J.A.C. 11:4-23A.8(a)1. The $5 million limit shall be applied on a consolidated basis for companies under common control.

(f) After the Commissioner has reviewed the annual report and the request for exemption, the Commissioner shall either grant or disapprove the request. Any request meeting the conditions of (e) above shall be deemed granted 30 days after its receipt by the Commissioner unless disapproved. The Commissioner may disapprove a request for one or more of the following reasons:

1. The request does not meet the enumerated conditions of (e) above;

2. The carrier or ODS has not filed a report, made a refund, or paid an assessment required by law applicable to a carrier or ODS; or

3. The Commissioner finds that an audit is necessary to verify the accuracy of the report or to otherwise meet the purposes of N.J.A.C. 11:22-1.9 and N.J.S.A. 17B:30-12 et seq.

(g) A carrier or ODS which has obtained an exemption from filing an audited annual report under (e) and (f) above shall also be exempt from filing quarterly Appendix A and B reports for the year following the year for which the exemption was obtained. If the carrier or ODS seeks an exemption from filing an audited annual report for the year following the year for which such an exemption

was previously obtained, a separate request for an exemption shall be required for the audited annual report for that ensuing year.

11:22-1.10 Remediation/penalty

(a) Upon review of the reports required by N.J.A.C. 11:22-1.9, the Commissioner may require that the carrier **or ODS**, at its own expense:

1.-2. (No change.)

(b) The Commissioner may impose a civil penalty of not more than $10,000 upon the carrier, to be collected pursuant to "the penalty enforcement law," N.J.S.A. 2A:58-1 et seq., if, following the remediation measures in (a) above, the Commissioner determines that:

1. (No change.)

2. A carrier, **ODS** or [its] **the** agent **of a carrier or ODS** has failed to pay interest as required pursuant to N.J.A.C. 11:22-1.7.

(a)

DEPARTMENT OF BANKING AND INSURANCE DIVISION OF INSURANCE

Health Benefit Plans
Exclusions and Preauthorization Requirements
Actuarial Services
Group Life, Group Health and Blanket Insurance: General Standards for Contract Provisions

Proposed New Rules: N.J.A.C. 11:22-6
Proposed Amendments: N.J.A.C. 11:4-42.5

Authorized By: Holly C. Bakke, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1 and 15e, 17B:27-49g, and 26:2J-43h.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2003-214.

Submit comments by August 1, 2003 to:

Douglas Wheeler, Assistant Commissioner
Department of Banking and Insurance
Legislative and Regulatory Affairs
20 West State Street
PO Box 325
Trenton, NJ 08625-0325
Fax: (609) 292-0896
Email: legsregs@dobi.state.nj.us

The agency proposal follows:

Summary

The National Association of Insurance Commissioners (NAIC) has been examining the issue of coverage by health insurance carriers of adverse reactions to smallpox vaccinations and secondary exposure to the disease through contact with a vaccinated person. Health contracts typically contain an exclusion for injury or illness due to declared or undeclared war. Questions have been raised recently as to whether carriers would invoke this exclusion and deny coverage to persons who experience adverse reactions to the smallpox vaccine or who become ill due to exposure to a vaccinated person. An informal survey of health carriers conducted by the Department indicated that it would be appropriate for the Department to clarify its policy on this issue. The purpose of this proposal is to set standards for war exclusions in health benefit plans and in group life insurance policies and certificates similar to those that apply in individual life insurance policies.

The Department has also noted that its current rules regarding preauthorization of medical services, including the 50 percent cap on the penalty where the service would have been covered but for failure to obtain preauthorization, are applicable to group health insurance but not to coverage provided by health maintenance organizations. The Department believes that persons covered by health maintenance organization contracts should be provided the same level of protection with respect to preauthorization as are persons covered by policies issued by health insurance companies. Accordingly, the Department is adding a section, N.J.A.C. 11:22-6.4, dealing with preauthorization in contracts issued by health maintenance organizations which contains essentially the same provisions as are applied to health insurance companies at N.J.A.C. 11:4-42.8 except for N.J.A.C. 11:4-42.8(a)5 because that paragraph refers to a statute that is not applicable to health maintenance organizations.

The Department's proposal adds a new subchapter to Chapter 22, Health Benefit Plans, which includes the following provisions:

N.J.A.C. 11:22-6.1 sets forth the purpose and scope of the proposed new subchapter.

N.J.A.C. 11:22-6.2 contains definitions of the terms used throughout the subchapter.

N.J.A.C. 11:22-6.3 establishes the Department's policy concerning military exclusions, non-combatant civilian exclusions and civilian exclusions in health benefit plans.

N.J.A.C. 11:22-6.4 provides that essentially the same standards applicable to preauthorization by health insurance companies shall apply to health maintenance organizations that utilize preauthorization.

N.J.A.C. 11:22-6.5 indicates that all noncomplying forms shall be deemed withdrawn as of January 1, 2004.

The Department is also amending N.J.A.C. 11:4-42, Group Life, Group Health and Blanket Insurance: General Standards for Contract Provisions, by adding language at N.J.A.C. 11:4-42.5, Prohibited provisions, that would only permit war exclusions in group life insurance policies and contracts that comply with the requirements of N.J.A.C. 11:4-41.4(a)3i through iii, Individual life insurance policy forms war exclusions. Text is also being added to this provision, for group policies and certificates providing life insurance, to specify that any amount payable due to a death from an excluded act shall not be less than the total premiums paid by or on behalf of the covered person.

As the Department has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

These proposed new rules and amendments will have a positive impact on New Jersey citizens. Clear standards for the scope of war exclusions in health benefit plans and group life insurance contracts will resolve any uncertainties as to the types of losses that may be excluded and what losses may not be excluded. Moreover, extension of the preauthorization requirements to health maintenance organizations further protects consumers by limiting the financial penalty imposed for failure to obtain preauthorization of a service that would otherwise be covered. At least one health maintenance organization currently denies all benefits for medically necessary services where preauthorization was not obtained. These rules limit this penalty to 50 percent in such situations, the same limit that applies to health insurance companies.

Economic Impact

These proposed new rules and amendments may unfavorably impact carriers because the Department is specifying clear standards for the scope of war exclusions in health benefit plans and group life insurance policies and contracts. To the extent that carriers currently have broader exclusions in these contracts, the exclusions will be limited in effect. Consumers will be favorably impacted because they cannot be denied coverage when appropriate.

Similarly, health maintenance organizations that deny benefits for medically necessary services for failure to obtain preauthorization will have an adverse economic impact because they will be required to pay at least 50 percent of the benefit in those situations. Consumers, on the other hand, will be favorably impacted because they will receive at least a 50 percent benefit rather than no benefit if they obtain medically necessary otherwise covered services that were not preauthorized.

Federal Standards Statement

A Federal standards analysis is not required because these new rules and amendments are not subject to any Federal standards or requirements.

Jobs Impact

The Department does not anticipate that the proposed new rules and amendments will result in the generation or loss of jobs.

Agriculture Industry Impact

The Department does not believe that the proposed new rules and amendments will have any impact on the agriculture industry in the State.